

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6729

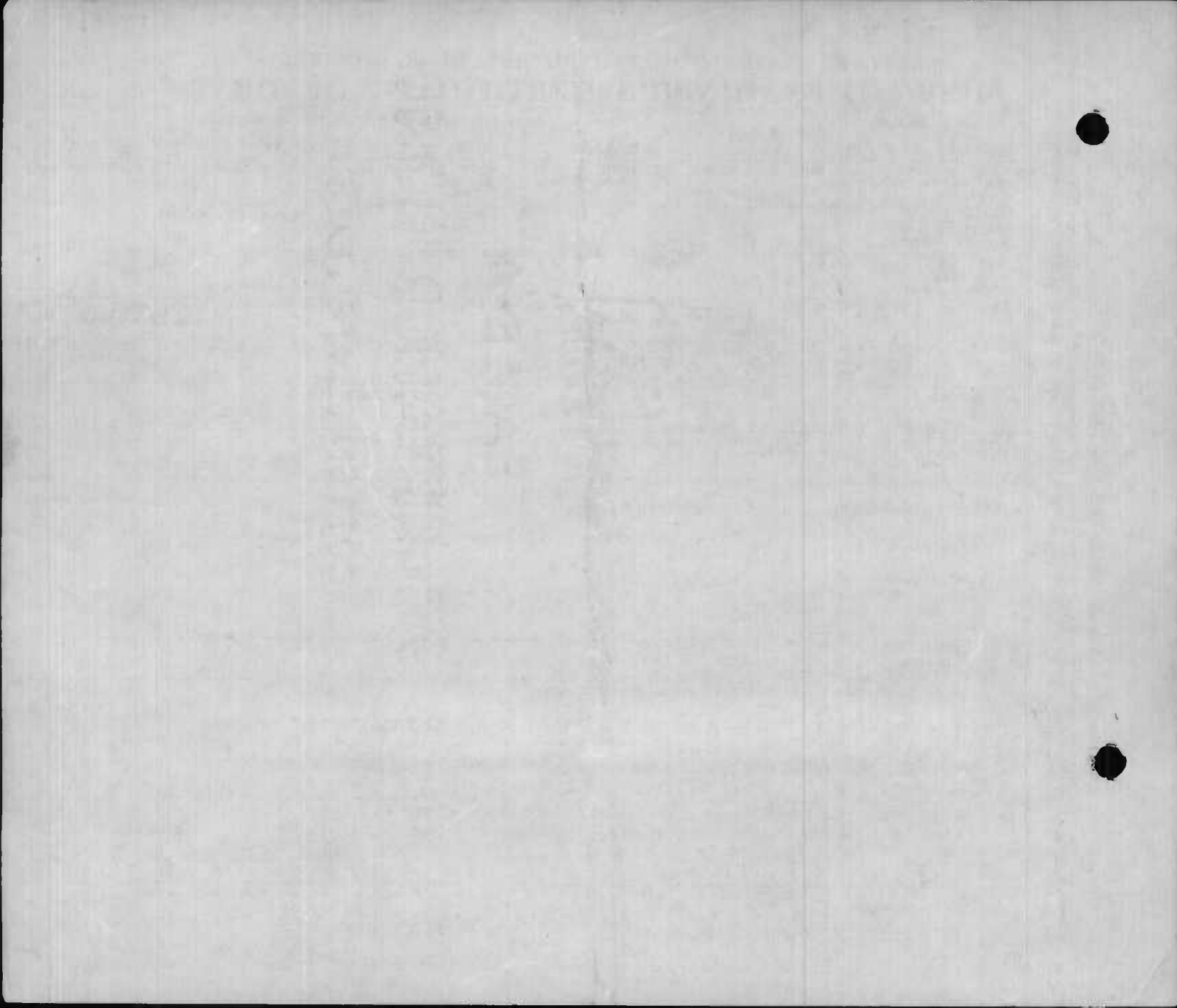
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Belair</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Nursing Home</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>Nellie K Anderson</i>		<i>July 22 1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Aug 13 - 1874</i>
9. AGE last birthday: <i>80</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>	11. BIRTHPLACE (State or foreign country): <i>Winchester Va</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <i>George W. Marple</i>	
14. MOTHER'S MAIDEN NAME: <i>Elizabeth Woodlock</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Lucie Anderson - 150 E Oliver St</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Arteriosclerotic CV disease</i>			
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER DATE SIGNED <i>7/22/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REG. <i>7-25-55</i>		REGISTRAR'S SIGNATURE <i>Wm Wood Inc - 1217 St Paul St</i>	



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06711

6720

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Bel Air Rural</u>		LENGTH OF STAY (in this place)		OR TOWN <u>Bel Air Rural</u>		STREET ADDRESS (If rural give location)	
X		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walter Moring Home</u>		STREET ADDRESS <u>Bel Air Md</u>		1	
3. NAME OF DECEASED (Type or Print) <u>Georgia Anna</u> (First) <u>Axt</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>July 27</u> 19 <u>55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE last birthday <u>About 90</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic C V disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 22, 1955</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Gerald E Palmer</u> M.D.				ADDRESS (Street, city, town, state) <u>Bel Air Md</u>		DATE SIGNED <u>7/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF GEMETORY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 31, 1955</u>		<u>Perryman</u>		<u>Harford Co, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 28, 1955</u>		<u>C. G. Klopfer</u>		<u>W. Bailey</u>		<u>Wilmington Md</u>	

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1806712<sup>VC</sup>  
 6721 **CERTIFICATE OF DEATH** Reg. Dist. No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Howard ?</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>Edgewood</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>RURAL Ellicott City</b> 13X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50 USAH APG Md</b>				STREET ADDRESS (If rural give location) <b>RFD #1</b> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Raymond Joseph Belardi</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>July 20 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH: <b>Sept 20 1914</b>	9. AGE last birthday <b>40</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Army Officer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>US Army</b>		11. BIRTHPLACE (State or foreign country): <b>Chicago, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Unknown Deceased</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown Deceased</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <b>yes</b> ✓ <b>unk</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS: <b>Official Army Records</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>816X</b>							
(A) DUE TO <b>Basilar skull fracture</b>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0 none</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>X</b>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? <b>Edgewood</b>		(County) <b>Harford</b> (State) <b>Md</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 20 1955 11P</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Automobile accident, auto-auto type</b>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
SIGNATURE <b>Gerald C Palmer</b>		ADDRESS <b>M. D. Deputy Medical Examiner 7121155</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		DATE THEREOF <b>July 23/1955</b>		NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>July 23-55</b>		REGISTRAR'S SIGNATURE <b>Mellie G. Perry</b>		24. FUNERAL DIRECTOR <b>John E. Tannis</b>		ADDRESS <b>Chardon Md</b>	

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VALLEY'S  
CONGRESS



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06713

6722

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bel Air</u>		<u>3 years</u>		TOWN <u>Bel Air</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>488 Atwood</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Hettie B Boston</u>				<u>July 7 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>May 26-1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Retired</u>				<u>Retired</u>		<u>Borden town N.J.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Green</u>				<u>Ephemia Brouwer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>9</u>				<u>✓</u>		<u>H. A. Atwood JR</u> <u>Mrs. M. R. R. BEL AIR MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>CEREBRO-VASCULAR ACCIDENT</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ADVANCED AGE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 5<sup>th</sup></u> to <u>July 7<sup>th</sup></u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 6<sup>th</sup></u> , 19 <u>55</u> , and that death occurred at <u>1230 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Alex. I. Sandeechi M.D.</u>				<u>BEL AIR, MD</u>			
DATE SIGNED				DATE SIGNED			
<u>July 7<sup>th</sup> 55</u>				<u>July 7<sup>th</sup> 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 9/55</u>		<u>Bel Air Memorial Gardens</u>		<u>BEL AIR MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-7-55</u>		<u>Priscilla F. Wood</u>		<u>Joseph J. Foster</u>		<u>Bel Air MD</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF DEATH

6. PLACE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. DISEASE OR INJURY

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF CEMETERY OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF OTHER

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DEPARTMENT OF HEALTH - BALTIMORE, MD.  
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BUREAU V. S.



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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

06714

Reg. Dist. No. 182

6723

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
X TOWN <b>Darlington Rural</b>		<b>15 mos.,</b>		TOWN <b>Darlington R.D.</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Edmond</b> (Middle) (Last) <b>Branham</b>				(Month) <b>July,</b> (Day) <b>8,</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>male</b>	<b>white</b>	<b>married</b>	<b>Mar. 9, 1854</b>	<b>101</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Farmer</b>		<b>Owner, Agriculture</b>		<b>Campbell Co., Virginia.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Richard Branham</b>				<b>Christine Wise</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>no</b>		<b>none</b>		<b>Samuel C. Branham, Darlington, R.D. Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
794 X IMMEDIATE CAUSE (A) <b>old age</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 1954</b> , to <b>July 8, 1955</b> , that I last saw the deceased alive on <b>July 3, 1955</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<b>Nicolson Eludby Phelps M.D.</b>		<b>Darlington Md.</b>		<b>7/9/55</b>		<b>Md.</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)			
<b>Burial</b>		<b>Glen Haven Memorial</b>		<b>Glen Burnie, Anne Arundel,</b>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>July 9, 1955</b>		<b>Cornelia W. Kirk</b>		<b>Howard K. McComas &amp; Son</b>		<b>Abingdon, Md.</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. DATE OF DEATH: [illegible]  
10. SIGNATURE: [illegible]

11. NAME OF PHYSICIAN: [illegible]  
12. NAME OF HOSPITAL: [illegible]  
13. NAME OF NURSE: [illegible]  
14. NAME OF MINISTER: [illegible]  
15. NAME OF CHURCH: [illegible]  
16. NAME OF FUNERAL HOME: [illegible]  
17. NAME OF CEMETERY: [illegible]  
18. NAME OF BURIAL PLACE: [illegible]  
19. NAME OF INTERMENT: [illegible]  
20. NAME OF CREMATION: [illegible]

21. NAME OF CORPSE: [illegible]  
22. NAME OF CASK: [illegible]  
23. NAME OF CASK: [illegible]  
24. NAME OF CASK: [illegible]  
25. NAME OF CASK: [illegible]  
26. NAME OF CASK: [illegible]  
27. NAME OF CASK: [illegible]  
28. NAME OF CASK: [illegible]  
29. NAME OF CASK: [illegible]  
30. NAME OF CASK: [illegible]

31. NAME OF CASK: [illegible]  
32. NAME OF CASK: [illegible]  
33. NAME OF CASK: [illegible]  
34. NAME OF CASK: [illegible]  
35. NAME OF CASK: [illegible]  
36. NAME OF CASK: [illegible]  
37. NAME OF CASK: [illegible]  
38. NAME OF CASK: [illegible]  
39. NAME OF CASK: [illegible]  
40. NAME OF CASK: [illegible]

41. NAME OF CASK: [illegible]  
42. NAME OF CASK: [illegible]  
43. NAME OF CASK: [illegible]  
44. NAME OF CASK: [illegible]  
45. NAME OF CASK: [illegible]  
46. NAME OF CASK: [illegible]  
47. NAME OF CASK: [illegible]  
48. NAME OF CASK: [illegible]  
49. NAME OF CASK: [illegible]  
50. NAME OF CASK: [illegible]

51. NAME OF CASK: [illegible]  
52. NAME OF CASK: [illegible]  
53. NAME OF CASK: [illegible]  
54. NAME OF CASK: [illegible]  
55. NAME OF CASK: [illegible]  
56. NAME OF CASK: [illegible]  
57. NAME OF CASK: [illegible]  
58. NAME OF CASK: [illegible]  
59. NAME OF CASK: [illegible]  
60. NAME OF CASK: [illegible]

BUREAU A. S.

JUL 15 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN <u>HAVRE DE GRACE</u> <u>24</u>	
TOWN <u>Bel Air</u>		<u>2 mo.</u>		STREET ADDRESS (If rural, give location)		<u>419 S UNION AVE.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WALTERS Nursing Home</u>							
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Emma</u> (Middle) <u>HAND</u> (Last) <u>Bristow</u>				(Month) <u>July</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov 15 1862</u>	9. AGE last birthday: <u>92</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>Wm L HAND</u>				14. MOTHER'S MAIDEN NAME: <u>Lidia Bennett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>UNK.</u>		17. INFORMANT & ADDRESS: <u>Emma Chandler 419 S UNION AVE</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Arteriosclerotic C V disease</u>							
DUE TO							
Antecedent cause(s) (b) _____							
Diseases or conditions, if any, giving rise to the above cause (c) _____							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: _____				19b. MAJOR FINDING OF OPERATION: _____			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) _____ (County) _____ (State) _____			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Ronald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/30/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>Aug 2/55</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL Cem</u>		LOCATION (City, town, or county) <u>HAVRE de Grace MD</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>8-1-55</u>		REGISTRAR'S SIGNATURE <u>Phyllis Towood</u>		24. FUNERAL DIRECTOR <u>Pennington &amp; Son, Havre Grace, MD</u>		ADDRESS _____	

INTERVAL BETWEEN ONSET AND DEATH

BUREAU V. S.

AUG 3 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06716

6711

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i> Cecil 07X-2</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Harford</i>		<i>12 days</i>		TOWN <i>Port Deposit Md RD #1</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hosp House de Grace Md</i>				STREET ADDRESS (If rural give location) <i>RD #1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Lucy Lyon Cowlson</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>July 13 1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb 24, 1886</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William T. Cowlson</i>				14. MOTHER'S MAIDEN NAME <i>Henrietta Rawlings</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Harford Memorial Hosp</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
153X IMMEDIATE CAUSE (A) <i>Carcinomatosis - Peritonitis</i>						<i>2 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Adenocarcinoma of colon</i>						<i>6 mos</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <i>July 10, 1955</i>		19b. MAJOR FINDINGS OF OPERATION <i>Adenocarcinoma of sigmoid colon with metastasis to peritoneum</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>June 30</i> , 19 <i>55</i> , to <i>July 13</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>July 12</i> , 19 <i>55</i> , and that death occurred at <i>12:08 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Ross J. Brierant</i>		M.D. <i>610 S Main Ave Harford Md</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>July 13, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7-15-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Hopewell</i>		LOCATION (City, town, or county) (State) <i>Port Deposit, Md. RD. 1</i>	
24. REC'D BY REGISTRAR <i>July 14 - 1955</i>		REGISTRAR'S SIGNATURE <i>G. L. Lewis</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Veera, Patterson &amp; Son</i>		ADDRESS <i>Perryville Md</i>	





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6724  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06717  
 Reg. Dist.

No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Churchville</u>		<u>3 years</u>		TOWN <u>Dablon MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <u>Thomas F</u>		(Middle)		(Last) <u>Davis Jr</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>21</u> (Year) <u>55</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>January 1 - 1937</u>	
				9. AGE last birthday: <u>18 years</u>		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during last work life, even if retired): <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country): <u>Alameda N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas J Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Aleene Hall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Thomas L Davis Darlington MD RD 2</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
816x Immediate cause (a) <u>Fracture skull</u>							
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )		21c. (City or town) (County) <u>Churchville Harford</u> (State) <u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/21/55</u> <u>54</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>A vt accident, auto auto type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/21/55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Vale</u>		LOCATION (City, town, or county) (State) <u>Galax, Va</u>	
DATE REC'D BY LOCAL REG. <u>7-21-55</u>		REGISTRAR'S SIGNATURE <u>Russella Toward</u>		24. FUNERAL DIRECTOR <u>Joe T Foster Bel Air Md</u>		ADDRESS	

BUREAU V. B.

MAY 25 1955

RECEIVED

6725

# CERTIFICATE OF DEATH

Reg. Dist. No. .... 181

Mrs Perry

## INSTRUCTIONS

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY OR TOWN <i>Hartford</i> <i>Aberdeen</i>	MARYLAND LENGTH OF STAY (in this place) <i>—</i>	STATE COUNTY <i>Maryland</i> <i>Hartford</i>	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rural #2 Churchville Aberdeen Road.</i>		STREET ADDRESS (If rural give location) <i>Churchville-Aberdeen Road.</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <i>Ruth Ida Yearn</i>		(Month) (Day) (Year) <i>July 2 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 12 - 1876</i>
9. AGE last birthday <i>78 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Thomas Buckingham</i>	
14. MOTHER'S MAIDEN NAME <i>Isabella Barnes</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Robt. Yearn - Aberdeen Rd #22</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>175X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Invasion Peritoneal Carcinomatosis Carcinoma of Ovary 1 wk 1 yr. 7 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>6-6-55</i>	19b. MAJOR FINDINGS OF OPERATION <i>Metastatic Carcinoma (Ovarian)</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work Not while at work	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1949</i> , to <i>7-2-55</i> , that I last saw the deceased alive on <i>July 19 1955</i> , and the death occurred at <i>7 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Vernon W. Williams M.D.</i>	ADDRESS (Street, city, town, state) <i>Aberdeen, Md.</i>	DATE SIGNED <i>7-4-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>7/5/1955</i>	NAME OF CEMETERY OR CREMATORY <i>Bakers cemetery</i>	LOCATION (City, town, or county) (State) <i>Aberdeen Md.</i>
24. REC'D BY REGISTRAR <i>J July 5-55</i>	REGISTRAR'S SIGNATURE <i>Nellie E. Perry</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Carrington</i>	ADDRESS <i>Aberdeen Md.</i>

# CERTIFICATE OF DEATH

Reg. Dis. No.

2. USUAL RESIDENCE (HOME) OF DECEASED

3. PLACE OF DEATH

CITY

MARYLAND

STATE

COUNTY

NAME OF

DECEASED

DATE

OF

DEATH

1. CAUSE OF DEATH

1. PLACE OF DEATH

10. MEDICAL CERTIFICATION

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF BURIAL SOCIETY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF FUNERAL HOME

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

BUREAU V. 3

JUL 7 1955

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or coroner who certifies the death. It is to be filed with the local health department or the state department of health. 2. The name of the deceased should be written in full, including the middle name if known. 3. The date of death should be written in full. 4. The place of death should be written in full. 5. The cause of death should be written in full. 6. The signature of the physician or coroner should be written in full. 7. The signature of the registrar should be written in full. 8. The signature of the coroner should be written in full. 9. The signature of the jury should be written in full. 10. The signature of the witnesses should be written in full. 11. The signature of the deceased should be written in full. 12. The signature of the next of kin should be written in full. 13. The signature of the burial society should be written in full. 14. The signature of the church should be written in full. 15. The signature of the cemetery should be written in full. 16. The signature of the funeral home should be written in full. 17. The signature of other should be written in full. 18. The signature of other should be written in full. 19. The signature of other should be written in full. 20. The signature of other should be written in full. 21. The signature of other should be written in full. 22. The signature of other should be written in full. 23. The signature of other should be written in full. 24. The signature of other should be written in full. 25. The signature of other should be written in full. 26. The signature of other should be written in full. 27. The signature of other should be written in full. 28. The signature of other should be written in full. 29. The signature of other should be written in full. 30. The signature of other should be written in full. 31. The signature of other should be written in full. 32. The signature of other should be written in full. 33. The signature of other should be written in full. 34. The signature of other should be written in full. 35. The signature of other should be written in full. 36. The signature of other should be written in full. 37. The signature of other should be written in full. 38. The signature of other should be written in full. 39. The signature of other should be written in full. 40. The signature of other should be written in full.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06719

6712

## CERTIFICATE OF DEATH

Item 12, FilmG184 8-5-55 et

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PORT DEPOSIT</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP</u>				STREET ADDRESS <u>N. MAIN</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANK</u> (First) <u>Di Giovanni</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>July 21, 1955</u> (Month) (Day) (Year)			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-26-1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERRICO DI GIOVANNI</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE SABLONE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Richard Di Giovanni, Port Deposit, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Cedars Cervicoma Segment</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1-15-55</u>				19b. MAJOR FINDINGS OF OPERATION <u>Cedars Cervicoma Segment</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> to <u>July 20, 1955</u> , that I last saw the deceased alive on <u>July 15, 1955</u> , and that death occurred at <u>1:13 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. J. Johnson, M.D.</u>				ADDRESS (Street, city, town, state) <u>Port Deposit, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. ERIN</u>		LOCATION (City, town, or county) (State) <u>HAURE DE GRACE, MD</u>	
24. REC'D BY REGISTRAR <u>July 23-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md</u>	



CERTIFICATE OF DEATH

Each Date No.

ST. MARY'S HOSPITAL, BALTIMORE, MARYLAND

MARYLAND

N. Main

17-26-1916 78

Merchant own store

FRISCO, TEXAS

Richard D. Garrison, 3817 Broadway

1

rs after death.

24

INSTRUCTIONS The law requires that the death certificate be executed within 24

1

HAN OR HOSPITAL: The law requires that the death certificate be executed within 24

TO ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24

1/24/1916

exam

BUREAU V. S.

Filed 18 27 Feb 20 21

12/24/16

7-23-22 MT ERIN

1916



6713

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
31 TOWN <u>Aberdeen</u>				31 TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
108 <u>128 Phila. Rd.</u>				128 <u>Phila. Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Victor</u> (Middle) <u>-</u> (Last) <u>Giudice</u>				(Month) <u>7</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>white</u>	<u>married</u>	<u>Feb. 16 - 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>shoe maker</u>		<u>Roppler emp.</u>		<u>Italy</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Angelo Giudice</u>				<u>Grace J. Venti</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>212-30-7683</u>		<u>Francis X. Giudice Wash. D. C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident</u>						<u>12 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Anemia of Rectum</u>						<u>3 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/14, 1955</u> , to <u>7/29, 1955</u> , that I last saw the deceased alive on <u>7/29, 1955</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Hatten</u>				ADDRESS (Street, city, town, state) <u>177 Phila. Rd. Aberdeen Md.</u>			
DATE <u>Aug 1-1955</u>				DATE SIGNED <u>7/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 1st 1955</u>		<u>Bakers cemetery</u>		<u>Aberdeen Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 1-1955</u>		<u>Phillip R. Perry</u>		<u>John G. Darring</u>		<u>Aberdeen Md.</u>	

HOSPITAL or hospital, or attending physician. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HC: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06721

6726

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR-RURAL</u> LENGTH OF STAY (in this place) <u>5 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR-RURAL</u> STREET ADDRESS (If rural give location) <u>TOLL GATE 1 South of BEL AIR ROAD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELMER ALBERT HAMMER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 7, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JAN. 6, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELMER HAMMER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA STOKES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>CLARK FITZPATRICK</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4222 IMMEDIATE CAUSE (A) <u>Ch Myocardial Disease -</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prostate Enlargement</u>				18. MEDICAL CERTIFICATION <u>BEL AIR MD.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>104 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 10, 1951</u> , to <u>July 7, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>		DATE THEREOF <u>JULY 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		LOCATION (City, town, or county) <u>Bel Air, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR DATE <u>7-7-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foster Funeral Home</u>		ADDRESS <u>Bel Air, Md.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. PLACE OF DEATH: [Faint text]

9. DATE OF DEATH: [Faint text]

10. SIGNATURE OF PHYSICIAN: [Faint text]

11. SIGNATURE OF REGISTRAR: [Faint text]

12. SIGNATURE OF WITNESSES: [Faint text]

13. SIGNATURE OF DECEASED: [Faint text]

14. SIGNATURE OF NEXT OF KIN: [Faint text]

15. SIGNATURE OF CLERGYMAN: [Faint text]

16. SIGNATURE OF BURIAL OFFICIAL: [Faint text]

17. SIGNATURE OF INTERVIEWER: [Faint text]

18. SIGNATURE OF DECEASED: [Faint text]

19. SIGNATURE OF NEXT OF KIN: [Faint text]

20. SIGNATURE OF CLERGYMAN: [Faint text]

21. SIGNATURE OF BURIAL OFFICIAL: [Faint text]

22. SIGNATURE OF INTERVIEWER: [Faint text]

23. SIGNATURE OF DECEASED: [Faint text]

24. SIGNATURE OF NEXT OF KIN: [Faint text]

25. SIGNATURE OF CLERGYMAN: [Faint text]

26. SIGNATURE OF BURIAL OFFICIAL: [Faint text]

27. SIGNATURE OF INTERVIEWER: [Faint text]

28. SIGNATURE OF DECEASED: [Faint text]

29. SIGNATURE OF NEXT OF KIN: [Faint text]

BUREAU V. S.

MAR 11 1955

RECEIVED

PHOTOGRAPH

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06722

6714

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>Harford</u> <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> STREET ADDRESS (If rural give location) <u>568 Queen</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Caroline B. Hawk</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7/31/55</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/5/1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George G. Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Rose Lawder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Arthur H Hawk, Harford, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1420.1 IMMEDIATE CAUSE (A) <u>Arterio Sclerosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/31</u> , 19 <u>55</u> , to <u>7/31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>55</u> , and that death occurred at <u>1:20</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford, Md</u>		DATE SIGNED <u>Aug 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) (State) <u>Harford, Md</u>	
24. REC'D BY REGISTRAR DATE <u>Aug 3-1955</u>		REGISTRAR'S SIGNATURE <u>U. L. Lewis m. d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Percey J. ...</u>		ADDRESS <u>Harford, Md</u>	



1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to determine what consumers want and what problems they are trying to solve. Once a need is identified, the next step is to develop a concept that addresses this need. This concept should be unique, valuable, and feasible. The third step is to create a prototype of the product. This allows the company to test the concept and make any necessary adjustments. Finally, the product is launched into the market, and the company monitors its performance and makes further improvements as needed.

BUREAU V. S.

8 AUG

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6727

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

06723

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>HARFORD</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>RURAL - WHITEFORD</b> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>R.D. #1</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <b>JULY 27, 1955</b>			
<b>MALINDA BELLE HERRING</b>							
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>Apr. 10, 1885</b>	9. AGE last birthday <b>70</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 YEAR Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>HOUSEKEEPER</b>				<b>SWIFT RUN, VA.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME: <b>GEORGE HERRING</b>				14. MOTHER'S MAIDEN NAME: <b>MARGARET SHIFFLETT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b># No</b>				<b>REESE EATON, YORK, PA.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>						<b>Immediate</b>	
ANTECEDENT CAUSE (S) DUE TO (B) <b>Hypertensive C-V Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <b>(260X)</b>							
C) <b>Dratke Mellitus</b>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1940 to July 27, 1955 that I last saw the deceased alive on July 27, 1955, and that death occurred at 220 M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>John A. Hunt M.D.</b>		<b>Delta, R.</b>		<b>7/28/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, of county) (State)	
<b>BURIAL</b>		<b>7-29-55</b>		<b>MT. ROSE</b>		<b>YORK, PA.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>8-1-55</b>		<b>Priscilla Foxwood</b>		<b>JOHN H. HARKINS, DELTA, PA.</b>			

BUREAU V. 2

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 180

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Harford</b>	MARYLAND	STATE <b>Florida</b>	COUNTY <b>Dade</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Abingdon</b>	LENGTH OF STAY (in this place) <b>7 days</b>	CITY (If outside corporate limits write RURAL and give nearest town) <b>TOWN Miami 48X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>10</b>		STREET ADDRESS (If rural, give location) <b>✓</b>	
3. NAME OF DECEASED: (Type or Print) <b>Elizabeth Hylan Hunter</b>		4. DATE OF DEATH <b>July 14 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>Nov. 15, 1874</b>
9. AGE last birthday: <b>80</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>none</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Alonza F. Cochran</b>		14. MOTHER'S MAIDEN NAME: <b>Elizabeth Hylan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>none</b>	
17. INFORMANT & ADDRESS: <b>Robert E. Hunter, 8309 Loch Raven Blvd., 4 Md.</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <b>443X Immediate cause (a) Hypertensive CV disease DUE TO</b> <b>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
19. DATE OF OPERATION: <b>0</b> 19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Lerald e Palmer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7/15/55</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>7/17/1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Mountain Christian</b>		LOCATION (City, town, or county) (State) <b>Jopps, Harford, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>July 17, 1955</b>		REGISTRAR'S SIGNATURE <b>Norma E. Moore</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b>		ADDRESS <b>Abingdon, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

July 19

1955

Department of Justice

BUREAU V. 2

JUL 20 1955

RECEIVED

James E. Sullivan

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06725

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## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Harford</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 House de Grace</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Harford Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Rebecca ELLEN Jones</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July 1<sup>st</sup> 1955</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widow</u>		<b>8. DATE OF BIRTH</b> <u>7/20/1877</u>	
<b>9. AGE last birthday</b> <u>77</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>HARFORD Co., MD.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John Henry MORRIS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Weaver</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u></u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Norman Bush, Rocks, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Complete Heart Block</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 yr.</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Coronary Arteriosclerosis</u>				<u>10 yr.</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u></u>							
<b>19a. DATE OF OPERATION</b> <u></u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u></u>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u></u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u></u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u></u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u></u>			
<b>22. I hereby certify that I attended the deceased from <u>6-23</u>, 19<u>55</u>, to <u>7-1</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6-30</u>, 19<u>55</u>, and that death occurred at <u>8:00 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. V. Norman, M.D.</u>				<b>DATE SIGNED</b> <u>7-1-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>July 4/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>VERNON</u>		<b>LOCATION (City, town, or county) (State)</b> <u>WHITEFORD MD.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>July 5-1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>A. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HARKINS FUNERAL DELTA</u>		<b>ADDRESS</b> <u>Geo. A. Jamison</u>	

# CERTIFICATE OF DEATH

Two copies to be filed

1. DECEASED PERSON'S NAME AND RESIDENCE

NAME AND RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

JUL 7 1955

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

## CERTIFICATE OF DEATH

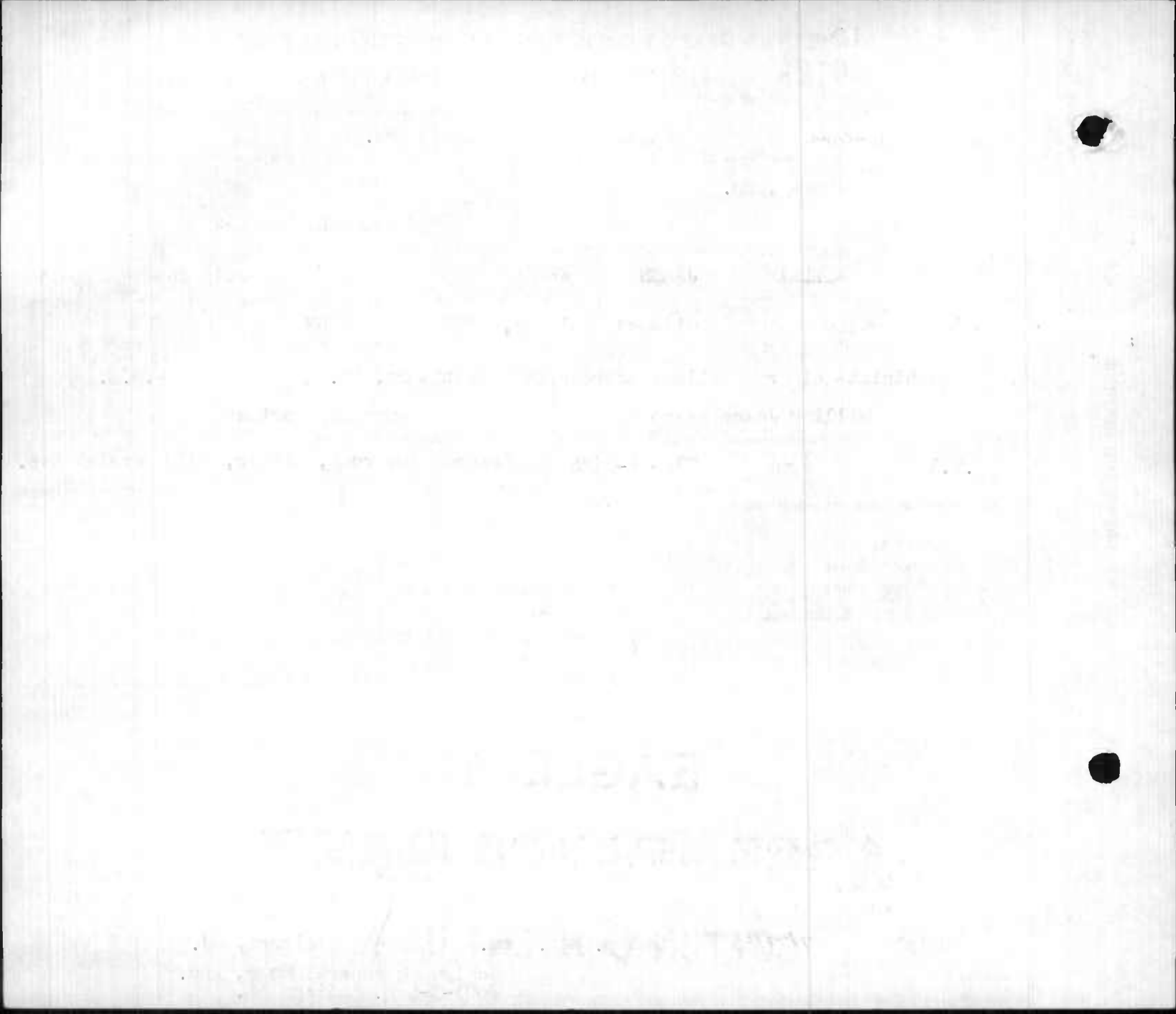
Reg. Dist. No. 185

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harf.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Joppa, Md.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Joppa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 464, Route 2</u>				STREET ADDRESS (If rural give location) <u>Box 464, Route 2</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>WILLIAM JAMES KELSO</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 24</u> 19 <u>55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 25, 1893</u>	9. AGE last birthday: <u>62</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist-Welder</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Railway Express Co</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>William James Kelso</u>			
14. MOTHER'S MAIDEN NAME: <u>Emma May Hartman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>W.W.I Army</u>			
16. SOCIAL SECURITY No. <u>714-05-6824</u>				17. INFORMANT & ADDRESS: <u>Frances Roycroft, sister, 2710 Berwick Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>241X CONGESTIVE HEART FAILURE</u>						1 YEAR	
ANTECEDENT CAUSE (S) (B) <u>COR PULMONALE</u>						3-4 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>BRONCHIAL ASTHMA, EMPHYSEMA AND ARTERIOSCLEROSIS</u>						10-15 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ASTHMA &amp; BRONCHITIS</u>							
19A. DATE OF OPERATION: <u>0 -</u>				19B. MAJOR FINDINGS OF OPERATION: <u>-</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT</u> , 1954, to <u>7/24</u> , 1955, that I last saw the deceased alive on <u>7/16</u> , 1955, and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B. Stewart Jr.</u>		ADDRESS <u>Box 95, Edgewood, Md</u>		DATE SIGNED <u>7/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-26-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>2601-3-5 E. Madison St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6730

06727 WC

Reg. Dist. No. 181

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<input checked="" type="checkbox"/> TOWN <u>RURAL ABERDEEN</u>				<u>RURAL ABERDEEN</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>ABERDEEN RD#2</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>W.</u>		<u>Edgar</u>		<u>King</u>		<u>July 12 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>		<u>1-11-1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MAINTENANCE CO. Bldg Education</u>		<u>Co. Bldg Education</u>		<u>HARFORD Co. MD</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JOSEPH L KING</u>				<u>ALICE LEE CHANNELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Edna E. Spurlin Bel Air Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> Immediate cause (a) <u>Hypertensive C V disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		<u>Gerald C Palmer</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-15-55</u>		<u>HIGHLAND</u>		<u>Highland, Harford Co. Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 11 '55</u>		<u>Bertha B. Knight</u> <u>Deputy</u>		<u>Kenneth W. Cashman</u> <u>Stewartstown Pa</u>			

BUREAU V. E.

JUL 19 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06728

6731

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Cecil</u>			
CITY OR TOWN <u>Bel Air, Rural</u>		CITY OR TOWN <u>Perryville</u>		CITY OR TOWN <u>Perryville</u>		CITY OR TOWN <u>Perryville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nurseing Home</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nurseing Home</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nurseing Home</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nurseing Home</u>	
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Arthur</u>		(Middle) <u>Mc</u>		(Last) <u>MULLAN</u>		(Date) <u>July 27 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>6-16-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McMullen</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>H.S. McMullen, Perryville, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						16 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Cerebral Episode with Left-sided hemiplegia--One yr ago.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. Prostatism--Urinary retention (Indwelling catheter--12 mos.)</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 8, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 26, 1955</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>William P. Hudson</u>				DATE SIGNED <u>7-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-29-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR <u>8-1-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Fowood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leola Patterson Sm, Perryville, Md.</u>		ADDRESS <u>Forest Hill, Md.</u>	

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

LOCAL HEALTH OFFICE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF TOWNSHIP CLERK

SIGNATURE OF COUNTY CLERK

SIGNATURE OF STATE CLERK

SIGNATURE OF VICE PRESIDENT

SIGNATURE OF SECRETARY

SIGNATURE OF TREASURER

SIGNATURE OF COMPTROLLER

SIGNATURE OF ATTORNEY GENERAL

SIGNATURE OF GOVERNOR

SIGNATURE OF VICE GOVERNOR

SIGNATURE OF JUDICIAL CLERK

SIGNATURE OF CLERK OF COURTS

BUREAU V. 2

AUG 3 1914

RECEIVED

J. B. McMillan, Secretary



6732

06729

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 180

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Joppa R.D.</b>		LENGTH OF STAY (in this place) <b>7 yrs</b>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Joppa, R.D.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <b>J. D. Mickel</b>				4. DATE OF DEATH <b>July 11 1955</b>			
5. SEX: <b>male</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>		8. DATE OF BIRTH: <b>Mar. 18, 1942</b>	
				9. AGE last birthday: <b>13</b> yrs.		10. UNDER 1 YEAR: <b>11</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>none</b>		11. BIRTHPLACE (State or foreign country): <b>North Carolina</b>	
13. FATHER'S NAME: <b>Walter T. Mickel</b>				14. MOTHER'S MAIDEN NAME: <b>Ora M. Settle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY No.: <b>none</b>		17. INFORMANT & ADDRESS: <b>J.W. Clements, Joppa, Maryland</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<b>929.8</b> Immediate cause (a) <b>Drowning</b> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) <b>giving rise to the above cause</b> DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <b>7/11/55</b>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Waters Run</b>		21c. (City or town) <b>Joppa</b> (County) <b>Harford</b> (State) <b>Md.</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7/11/55 2:00 P. M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Was epileptic. Drowned in Run</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>Lorald C Palmer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <b>7/11/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>July, 13, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>	
LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>		DATE REC'D BY LOCAL REG. <b>July 13, 1955</b>		REGISTRAR'S SIGNATURE <b>Norma B. Moore</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b>		ADDRESS <b>Abingdon, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1955

BUREAU V. 2

6716

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre de Grace</u>		<u>19 days</u>		TOWN <u>Harre de Grace</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Harford Memorial Hospital</u>				<u>Post Road So. Taylor's</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Ralph</u>				<u>July 11 1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>male</u>		<u>white</u>		<u>widowed</u>		<u>Jan 15, 1880</u>	
						9. AGE last birthday	
						<u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Salesman</u>		<u>Home Tel Co</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jesse Moore</u>				<u>MARY Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>215-05-1570</u>		<u>Post Road</u>			
				<u>Lillian Byers Harre De Grace</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
600.0 IMMEDIATE CAUSE (A)				<u>Acute pyelonephritis and meningococcal</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
<u>1. @ Colon, 2. Fibrosis - left, 3. A.s.c.v.D.</u>				<u>1 we.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 22</u> , 19 <u>55</u> , to <u>July 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>55</u> , and that death occurred at <u>12:30 P.</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Edward F. O'Connell</u>				<u>420 N. Union Ave. Harre de Grace, Md. 7th</u>		<u>July 11</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 14/55</u>		<u>Landon PK</u>		<u>Balto.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 4, 1956</u>		<u>W. L. Lewis</u>		<u>Loring Byers</u>		<u>5005 PK Hgth Balto 15, Md.</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Rev. 10-1-54

1. FORMAL NUMBER OF DEATH

MARYLAND

DEATH

BUREAU V. S.

AUG 4 1955

RECEIVED

DATE

34. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

33. REMOVAL (SPECIFY)  
BURNING, CEMETERY

32. VISC 1-2  
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06731

6717

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>HARVE C. Grace</u>		1 day		TOWN <u>DARLINGTON</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>HARford Memorial Hosp.</u>				<u>R.F.D. - 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wilson</u> (Middle) <u>Presberry</u> (Last)				(Month) <u>July</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>CE</u>	<u>MARRIED</u>	<u>12/15/1909</u>	<u>45</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Janitor</u>		<u>NAVAL BASE</u>		<u>HARford Co.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Presberry</u>				<u>Susan Washington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>219-03-0218</u>		<u>Mrs. Lillian Presberry - Darlington, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
493X IMMEDIATE CAUSE (A) <u>Congestive Heart failure</u>						<u>160h</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>old TB</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 18, 1955</u> , to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Malcolm D. Phillips</u> M.D.				<u>Darlington Md</u>		<u>7/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>7-6-55</u>		<u>Berekeley Cemetery</u>		<u>Darlington, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 5 - 1955</u>		<u>A. L. Lewis M.D.</u>		<u>Charles J. Bullock - Harve C. Grace, Md.</u>			

THE UNIVERSITY OF CHICAGO PRESS

BUREAU V. S.

JUL 2 1955

RECEIVED



INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06732

6718

## CERTIFICATE OF DEATH

Reg. Dist. No. 186-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace</u>		<u>11+R.</u>		TOWN <u>Harre-de-Grace</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
<b>3. NAME OF DECEASED</b> (Type of Print) <u>Howard Norton Rust</u>				<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 28, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store-owner GROCERY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERICK W<sup>m</sup>. RUST</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE KNOOP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-1639</u>		17. INFORMANT & ADDRESS <u>MRS. THELM M. RUST</u>		<u>HARRE DE GRACE R.D. #1</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion with myocardial infarction.</u>						<u>sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 29th</u> , 19 <u>55</u> , to <u>July 29th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>7:43 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Howard Norton Rust</u>				ADDRESS (Street, city, town, state) <u>420 N. Union Ave. Harre de Grace, Md 71301</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8-1-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Co. MD.</u>	
24. REC'D BY REGISTRAR <u>Aug. 1-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. MADISON MITCHELL</u>		ADDRESS <u>HARRE DE GRACE MD.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 187

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Churchville</u>	LENGTH OF STAY (in this place) <u>16 years</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Dublin RD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Russell Sage</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 21 1935</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 24-1938</u>
9. AGE last birthday: <u>16 years</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Volney Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Frank Sage</u>		14. MOTHER'S MAIDEN NAME: <u>Reba Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Frank Sage Darlington Md. RD</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
<u>816X</u> Immediate cause (a) <u>Emaciation cerebrum</u> DUE TO			
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Route 136</u>	21c. (City or town) (County) (State) <u>Churchville</u> <u>Hartford</u> <u>MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>July 21, 1935 5A.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto accident, auto auto type</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Gerald C Palmer</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>July 21, 1935</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>July 23/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Rugby Baptist</u>	LOCATION (City, town, or county) (State): <u>Rugby Va</u>
DATE REC'D BY LOCAL REG. <u>7-21-55</u>	REGISTRAR'S SIGNATURE: <u>Priscilla Forward</u>	24. FUNERAL DIRECTOR: <u>Joseph Hated Bel Air Md</u>	ADDRESS

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06734

6734

# CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u> <u>Aberdeen Proving Ground Md</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> <u>Indiana</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u> <u>Evansville</u> STREET ADDRESS <u>Meeker Park Drive</u> <u>Lincoln Avenue</u> (see birth cert.)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Steven</u> <u>Harold</u> <u>SILKEY</u> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July</u> <u>18</u> <u>1955</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>16 July 1955</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>-</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
<b>13. FATHER'S NAME</b> <u>Gene Harold Silkey</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Kalah Jean Allen</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>	<b>17. INFORMANT &amp; ADDRESS</b> <u>Official Army Records</u>
<b>18. MEDICAL CERTIFICATION</b> <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>762.0 IMMEDIATE CAUSE (A) <u>atelectasis of lung, left (massive)</u></u> <u>ANTECEDENT CAUSE(S) DUE TO</u> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>DUE TO</u> <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Congenital stenosis of left main bronchus</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Alfred J. Rossi</u> <b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b> <u>US Army Hospital Aberdeen Prov Grd Md 18 Jul 55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>7/20/55</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>-</u>
<b>24. REC'D BY REGISTRAR</b> <u>July 20 - 55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mollie G. Perry</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Tarrig</u>
<b>DATE</b> <u>2075191444</u>		<b>ADDRESS</b> <u>Evansville, Indiana</u> <u>Aberdeen Md</u>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED PERSON'S NAME (PRINT OR TYPE)

2. SEX (PRINT OR TYPE)

3. AGE (PRINT OR TYPE)

4. DATE OF BIRTH (PRINT OR TYPE)

5. PLACE OF BIRTH (PRINT OR TYPE)

6. OCCUPATION (PRINT OR TYPE)

7. MARITAL STATUS (PRINT OR TYPE)

8. CAUSE OF DEATH (PRINT OR TYPE)

9. PLACE OF DEATH (PRINT OR TYPE)

10. DATE OF DEATH (PRINT OR TYPE)

11. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)

12. SIGNATURE OF WITNESS (PRINT OR TYPE)

13. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)

14. SIGNATURE OF CORONER (PRINT OR TYPE)

15. SIGNATURE OF JURY (PRINT OR TYPE)

16. SIGNATURE OF JUDGE (PRINT OR TYPE)

17. SIGNATURE OF CLERK (PRINT OR TYPE)

18. SIGNATURE OF NOTARY (PRINT OR TYPE)

19. SIGNATURE OF REGISTRAR (PRINT OR TYPE)

20. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)

21. SIGNATURE OF WITNESS (PRINT OR TYPE)

22. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)

23. SIGNATURE OF CORONER (PRINT OR TYPE)

24. SIGNATURE OF JURY (PRINT OR TYPE)

25. SIGNATURE OF JUDGE (PRINT OR TYPE)

26. SIGNATURE OF CLERK (PRINT OR TYPE)

27. SIGNATURE OF NOTARY (PRINT OR TYPE)

28. SIGNATURE OF REGISTRAR (PRINT OR TYPE)

29. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)

30. SIGNATURE OF WITNESS (PRINT OR TYPE)

31. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)

32. SIGNATURE OF CORONER (PRINT OR TYPE)

33. SIGNATURE OF JURY (PRINT OR TYPE)

34. SIGNATURE OF JUDGE (PRINT OR TYPE)

35. SIGNATURE OF CLERK (PRINT OR TYPE)

BUREAU V. 2

JUL 21 1955

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PHOTOGRAPH

1. DECEASED PERSON'S NAME (PRINT OR TYPE)  
2. SEX (PRINT OR TYPE)  
3. AGE (PRINT OR TYPE)  
4. DATE OF BIRTH (PRINT OR TYPE)  
5. PLACE OF BIRTH (PRINT OR TYPE)  
6. OCCUPATION (PRINT OR TYPE)  
7. MARITAL STATUS (PRINT OR TYPE)  
8. CAUSE OF DEATH (PRINT OR TYPE)  
9. PLACE OF DEATH (PRINT OR TYPE)  
10. DATE OF DEATH (PRINT OR TYPE)  
11. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)  
12. SIGNATURE OF WITNESS (PRINT OR TYPE)  
13. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)  
14. SIGNATURE OF CORONER (PRINT OR TYPE)  
15. SIGNATURE OF JURY (PRINT OR TYPE)  
16. SIGNATURE OF JUDGE (PRINT OR TYPE)  
17. SIGNATURE OF CLERK (PRINT OR TYPE)  
18. SIGNATURE OF NOTARY (PRINT OR TYPE)  
19. SIGNATURE OF REGISTRAR (PRINT OR TYPE)  
20. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)  
21. SIGNATURE OF WITNESS (PRINT OR TYPE)  
22. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)  
23. SIGNATURE OF CORONER (PRINT OR TYPE)  
24. SIGNATURE OF JURY (PRINT OR TYPE)  
25. SIGNATURE OF JUDGE (PRINT OR TYPE)  
26. SIGNATURE OF CLERK (PRINT OR TYPE)  
27. SIGNATURE OF NOTARY (PRINT OR TYPE)  
28. SIGNATURE OF REGISTRAR (PRINT OR TYPE)  
29. SIGNATURE OF DECEASED PERSON (PRINT OR TYPE)  
30. SIGNATURE OF WITNESS (PRINT OR TYPE)  
31. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)  
32. SIGNATURE OF CORONER (PRINT OR TYPE)  
33. SIGNATURE OF JURY (PRINT OR TYPE)  
34. SIGNATURE OF JUDGE (PRINT OR TYPE)  
35. SIGNATURE OF CLERK (PRINT OR TYPE)



## CERTIFICATE OF DEATH

Reg. Dist. No. 182

6735

14-File Q 183 8/3/55

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X <u>High Point</u>		<u>8 yrs</u>		TOWN <u>High Point</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
				<u>Forest Hill</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Russell Theodore</u> (Middle) <u>Strecker</u> (Last)				(Month) <u>July</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 8-1910</u>	<u>45</u> yrs.	Months <u>4</u> Days <u>12</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Sign Painter</u>			<u>Gravestone Center</u>		<u>Baltimore City</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Otto Strecker</u>				<u>Ida Shron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>243-10-0370</u>		<u>Mrs Marian E. Strecker</u> <u>Forest Hill Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Natural Cause</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>55</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Donald C Palmer</u>		<u>Deputy Medical Examiner</u>		<u>7/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>July 24-55</u>		<u>Jarrettville</u>		<u>Jarrettville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-30-55</u>		<u>Priscilla Louwood</u>		<u>Marion E. Strecker</u>		<u>Forest Hill Md.</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

27/8

10. 6. 51

No. —  
 Otto Stecker  
 2nd Street  
 St. Louis, Mo.  
 Mark White  
 1st Street  
 St. Louis, Mo.  
 July 22

BUREAU V.

AUG 3 1955

*(The following information was obtained from the records of the Department of Health, State of New York, dated August 3, 1965.)*

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06736

6736

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hickory</u>		<u>6 mo.</u>		TOWN <u>Hyde. Rural</u>		<u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EIMA</u> (Middle) (Last) <u>TEMPLE</u>				(Month) <u>July</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>March-8-1892</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co- Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Jackson Martin</u>				14. MOTHER'S MAIDEN NAME <u>Menerva Kennedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank J. Wilson 1616 York Balto Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						48 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-Vascular Disease</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1954</u> , 19 <u>55</u> , to <u>July 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 9</u> , 19 <u>55</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>7-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 13, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Fork Christian Ch. Cem.</u>		LOCATION (City, town, or county) (State) <u>Fork, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Arthur</u>		ADDRESS <u>Fork, Md</u>	
DATE <u>7-12-55</u>							

*[The page contains faint, illegible text, likely bleed-through from the reverse side.]*

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1955 51 708



**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06737

# CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Aberdeen</b>		<b>11hr 20min</b>		TOWN <b>Aberdeen</b>		<b>31</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>US Army Hospital</b>				STREET ADDRESS (If rural give location)			
<b>Aberdeen Proving Ground Md</b>				<b>406 Roberts Way</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>(Infant son) VALENTINE</b>				<b>July 13 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>Male</b>	<b>White</b>	<b>Single</b>	<b>July 13 1955</b>			<b>11 20</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>None</b>		<b>None</b>		<b>Maryland</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>George Colles Valentine</b>				<b>Elizabeth Jane Pfeiffer</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>None</b>		<b>Father 406 Roberts Way Aberdeen Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>11hr 20min</b>	
<b>776X IMMEDIATE CAUSE (A) Prematurity</b>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
<b>None</b>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>			<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from July 13, 1955, to July 13, 1955, that I last saw the deceased alive on July 13, 1955, and that death occurred at 2255p.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Alfred J. Fox</i>				<b>ADDRESS</b> (Street, city, town, state) <b>US Army Hospital Aberdeen Md</b>		<b>DATE SIGNED</b> <b>14 July 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Cremation</b>		<b>7/16/55</b>		<b>Greenmount Cemetery</b>		<b>Balto. Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>July 16-55</b>		<i>Mellie G. Perry</i>		<i>John G. Tarring</i>		<b>Aberdeen Md.</b>	
<b>2075222261</b>							



# CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of registrar (Print or write full name)

12. Signature of witness (Print or write full name)

13. Signature of witness (Print or write full name)

14. Signature of witness (Print or write full name)

15. Signature of witness (Print or write full name)

16. Signature of witness (Print or write full name)

17. Signature of witness (Print or write full name)

18. Signature of witness (Print or write full name)

19. Signature of witness (Print or write full name)

20. Signature of witness (Print or write full name)

21. Signature of witness (Print or write full name)

22. Signature of witness (Print or write full name)

23. Signature of witness (Print or write full name)

24. Signature of witness (Print or write full name)

25. Signature of witness (Print or write full name)

26. Signature of witness (Print or write full name)

27. Signature of witness (Print or write full name)

28. Signature of witness (Print or write full name)

29. Signature of witness (Print or write full name)

30. Signature of witness (Print or write full name)

BUREAU V. 2

JUL 20 1955

RECEIVED

ENCLOSURE

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06738

6719

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAURE DE GRACE</u>		<u>12 HRS.</u>		TOWN <u>HAURE DE GRACE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location) <u>R D</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES MARIAN WEBB</u>				<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 12, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer shares</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAYETTE WEBB</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA VAN DYKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>IRVIN WEBB RISING SUN</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>				<u>16 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>7/10</u>, 19<u>55</u>, to <u>7/11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>7/11</u>, 19<u>55</u>, and that death occurred at <u>10:34</u> A.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>Thorn H. Wachsman</u> M.D.		ADDRESS (Street, city, town, state) <u>Harford State Rd</u>		DATE SIGNED <u>7/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Osborn Cem.</u>		LOCATION (City, town, or county) (State) <u>NEAR PERRYVILLE MD.</u>	
24. REC'D BY REGISTRAR <u>July 11-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Tyson</u>		ADDRESS <u>Rising Sun Md.</u>	

# CERTIFICATE OF DEATH

1955

NOTIFICATION

THE DEPARTMENT OF HEALTH, BOSTON, MASSACHUSETTS, HAS RECEIVED A REPORT OF THE DEATH OF A PERSON WHOSE NAME AND ADDRESS ARE GIVEN BELOW. THE DEATH OCCURRED ON JULY 13, 1955, AT THE HOME OF THE DECEASED, 1234 MAIN STREET, BOSTON, MASSACHUSETTS. THE DECEASED WAS A WHITE MALE, BORN JULY 1, 1900, IN BOSTON, MASSACHUSETTS. HE WAS A RESIDENT OF BOSTON, MASSACHUSETTS, AT THE TIME OF HIS DEATH. THE CAUSE OF DEATH WAS HEART DISEASE. THE DEATH WAS REPORTED BY THE NEAREST RELATIVE, J. J. JONES, JR., 1234 MAIN STREET, BOSTON, MASSACHUSETTS. THE DEATH WAS REPORTED TO THE DEPARTMENT OF HEALTH, BOSTON, MASSACHUSETTS, ON JULY 14, 1955. THE DEATH WAS REPORTED BY THE NEAREST RELATIVE, J. J. JONES, JR., 1234 MAIN STREET, BOSTON, MASSACHUSETTS. THE DEATH WAS REPORTED TO THE DEPARTMENT OF HEALTH, BOSTON, MASSACHUSETTS, ON JULY 14, 1955.

BUREAU V. L.

JUL 13 1955

RECEIVED